

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13780

CERTIFICATE OF DEATH

13768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Maryland</i> <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>82 yrs</i>		d. STREET ADDRESS <i>609 N. Stokes</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles Nelson Barnard</i>		4. DATE OF DEATH Month <i>12</i> Day <i>13</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/11/1876</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Comm. Railroad</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Barnard</i>		14. MOTHER'S MAIDEN NAME <i>Ellen Taylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. C.N. Barnard</i>		Address <i>609 N. Stokes Harford, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X Cardiac insufficiency</i> DUE TO <i>Cardio-vascular renal reserve</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cardio-vascular renal reserve</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 1973</i> to <i>12/13/58</i> , that I last saw the deceased alive on <i>12/13/58</i> , and that death occurred at <i>12:17 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>C. N. Barnard M.D.</i>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>12/16/58</i>	<i>Angel Hill</i>	<i>Harford Harford, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. R. Barnard</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 18 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Knox</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13807

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POA Aberdeen Station Hagg.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aberdeen, MD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John Robert Baxter</u> First Middle Last				4. DATE OF DEATH <u>December 4</u> 19 <u>58</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1958</u>	9. AGE (In years last birthday) <u>2</u> yrs.	IF UNDER 1 YEAR Months <u>2</u> Days <u>4</u> Hours <u>19</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Hugh Roger Baxter</u>				14. MOTHER'S MAIDEN NAME <u>Dedwig Hagenreiner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u>		17. INFORMANT <u>Hugh R. Baxter, 6 Essex Pl. Aberdeen, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 12-4-58 DATE SIGNED					
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>Bell Air Md.</u>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Post Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen Proving Ground, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barriug</u>		ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thoma</u>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13770

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Market Street	
3. NAME OF DECEASED (Type or print) First NATHAN Middle BOULWARE Last (BOLDWELL)		4. DATE OF DEATH Month December Day 1 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1915
9. AGE (in years last birthday) 43 yrs.		IF UNDER 1 YEAR Months 13 Days 13	IF UNDER 24 HRS. Hours 13 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY LABORER	
11. BIRTH PLACE (State or foreign country) Ridgeway, S. CAR.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME GEORGE BOULWARE		14. MOTHER'S MAIDEN NAME RACHEL BENSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNK		16. SOCIAL SECURITY NO. 33-1029-557	
17. INFORMANT EMMA MOODY		Address 700W 3rd ST CHESTER, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral Injury 816x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto in auto-truck collision	
20c. TIME OF INJURY Month, Day, Year 10:55 p.m. 11/26/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	20f. (City or town) (County) (State) Edgewood Harford Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Paul F. Guerin		DATE SIGNED 12/1/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF UNK	22c. NAME OF CEMETERY OR CREMATORY UNK	22d. LOCATION (City, town, or county) (State) FELTONSVILLE Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Catherine Blaine		24a. REC'D BY REGISTRAR DEC 8 '58	
ADDRESS 2126 W 4th		24b. REGISTRAR'S SIGNATURE Arthur L. House	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1881

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Pennsylvania

Clinton

Female, 20 years

Heart & Lungs (see also)

AT 11

1881

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13782

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13771

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>	c. LENGTH OF STAY IN 1b <u>—</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pylesville (Rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DoA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Street Rd.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>SUSIE</u>	First <u>Agnes</u> Middle <u>Bush</u> Last	4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1928</u> 30 yrs.
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sewing Machine Operator, Factory</u>	11. BIRTHPLACE (State or foreign country) <u>W. Va</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Not Known</u>	
14. MOTHER'S MAIDEN NAME <u>Fern Cochran</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>180-22-3417</u>		17. INFORMANT <u>Mrs David Bush Pylesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture skull</u> 816 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto-auto collision (M.V. Comm)</u>	
20c. TIME OF INJURY Month, Day, Year <u>4</u> Hour <u>am</u> <u>Dec 30 58</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>State Highway</u>	20f. (City or town) (County) (State) <u>Harford Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . And in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>12-30-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 2 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wm Watters, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>Cooktown, Harford, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Skutz Janetteville, Md</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Dept. of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE PLAIN BROOK

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. OCCUPATION		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY	
13. PRESENT ILLNESS		14. PREVIOUS ILLNESSES		15. SURGICAL HISTORY	
16. MEDICATIONS		17. TREATMENT		18. OTHER INFORMATION	
19. SIGNATURE OF MEDICAL EXAMINER		20. SIGNATURE OF WITNESSES		21. SIGNATURE OF REGISTRAR	
22. DATE OF CERTIFICATE		23. TIME OF CERTIFICATE		24. PLACE OF CERTIFICATE	

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ABC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13772

CERTIFICATE OF DEATH

13808

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Hartford</u>	
CITY OR TOWN <u>Forest Hill</u>		LENGTH OF STAY (in this place) <u>16 years</u>		CITY OR TOWN <u>Forest Hill</u>		RURAL <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>HENRY ALBERT Carcaud</u>				<u>Dec 17 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 4 1866</u>	9. AGE last birthday <u>92</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Engineer RR</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas Carcaud</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth A Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>✓</u> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT & ADDRESS <u>MRS ESN H WILG'S Forest Hill Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Cardio-vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 48</u> , 19 <u>58</u> , to <u>Dec. 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 17</u> , 19 <u>58</u> , and that death occurred at <u>11:00 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William P. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Forest Hill, Md.</u>		DATE SIGNED <u>12-18-58</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>Dec 19/58</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. H. G. Kneass</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joe J. Belan</u>		ADDRESS	
DATE <u>DEC 22 '58</u>							

1. Name of deceased: **JOHN J. LATHROP JR. MARYLAND**
 2. Date of death: **1940**
 3. Place of death: **BALTIMORE, MARYLAND**
 4. Cause of death: **Heart disease**
 5. Date of burial: **1940**
 6. Place of burial: **BALTIMORE, MARYLAND**
 7. Name of funeral home: **JOHN J. LATHROP JR. MARYLAND**
 8. Name of physician: **JOHN J. LATHROP JR. MARYLAND**
 9. Name of undertaker: **JOHN J. LATHROP JR. MARYLAND**
 10. Name of cemetery: **BALTIMORE, MARYLAND**
 11. Name of church: **BALTIMORE, MARYLAND**
 12. Name of family: **BALTIMORE, MARYLAND**
 13. Name of friends: **BALTIMORE, MARYLAND**
 14. Name of neighbors: **BALTIMORE, MARYLAND**
 15. Name of relatives: **BALTIMORE, MARYLAND**
 16. Name of friends: **BALTIMORE, MARYLAND**
 17. Name of neighbors: **BALTIMORE, MARYLAND**
 18. Name of relatives: **BALTIMORE, MARYLAND**
 19. Name of friends: **BALTIMORE, MARYLAND**
 20. Name of neighbors: **BALTIMORE, MARYLAND**
 21. Name of relatives: **BALTIMORE, MARYLAND**
 22. Name of friends: **BALTIMORE, MARYLAND**
 23. Name of neighbors: **BALTIMORE, MARYLAND**
 24. Name of relatives: **BALTIMORE, MARYLAND**
 25. Name of friends: **BALTIMORE, MARYLAND**
 26. Name of neighbors: **BALTIMORE, MARYLAND**
 27. Name of relatives: **BALTIMORE, MARYLAND**
 28. Name of friends: **BALTIMORE, MARYLAND**
 29. Name of neighbors: **BALTIMORE, MARYLAND**
 30. Name of relatives: **BALTIMORE, MARYLAND**
 31. Name of friends: **BALTIMORE, MARYLAND**
 32. Name of neighbors: **BALTIMORE, MARYLAND**
 33. Name of relatives: **BALTIMORE, MARYLAND**
 34. Name of friends: **BALTIMORE, MARYLAND**
 35. Name of neighbors: **BALTIMORE, MARYLAND**
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 37. Name of friends: **BALTIMORE, MARYLAND**
 38. Name of neighbors: **BALTIMORE, MARYLAND**
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 43. Name of friends: **BALTIMORE, MARYLAND**
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 60. Name of relatives: **BALTIMORE, MARYLAND**
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 74. Name of neighbors: **BALTIMORE, MARYLAND**
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 76. Name of friends: **BALTIMORE, MARYLAND**
 77. Name of neighbors: **BALTIMORE, MARYLAND**
 78. Name of relatives: **BALTIMORE, MARYLAND**
 79. Name of friends: **BALTIMORE, MARYLAND**
 80. Name of neighbors: **BALTIMORE, MARYLAND**
 81. Name of relatives: **BALTIMORE, MARYLAND**
 82. Name of friends: **BALTIMORE, MARYLAND**
 83. Name of neighbors: **BALTIMORE, MARYLAND**
 84. Name of relatives: **BALTIMORE, MARYLAND**
 85. Name of friends: **BALTIMORE, MARYLAND**
 86. Name of neighbors: **BALTIMORE, MARYLAND**
 87. Name of relatives: **BALTIMORE, MARYLAND**
 88. Name of friends: **BALTIMORE, MARYLAND**
 89. Name of neighbors: **BALTIMORE, MARYLAND**
 90. Name of relatives: **BALTIMORE, MARYLAND**
 91. Name of friends: **BALTIMORE, MARYLAND**
 92. Name of neighbors: **BALTIMORE, MARYLAND**
 93. Name of relatives: **BALTIMORE, MARYLAND**
 94. Name of friends: **BALTIMORE, MARYLAND**
 95. Name of neighbors: **BALTIMORE, MARYLAND**
 96. Name of relatives: **BALTIMORE, MARYLAND**
 97. Name of friends: **BALTIMORE, MARYLAND**
 98. Name of neighbors: **BALTIMORE, MARYLAND**
 99. Name of relatives: **BALTIMORE, MARYLAND**
 100. Name of friends: **BALTIMORE, MARYLAND**

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

Reg. Dist. No.

1. Usual Residence (House or Decedent)

2. Place of Death

MARYLAND

COUNTY

NAME OF DECEASED

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

MARK OF DECEASED

DATE OF DEATH

MARK OF DECEASED

DATE OF DEATH

MARK OF DECEASED

DATE OF DEATH

MARK OF DECEASED

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MARK OF DECEASED

DATE OF DEATH

CERTIFICATE OF DEATH

13773

Reg. Dist. No.

13783

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>241 HAVRE DE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 CHESAPEAKE DRIVE</u>				d. STREET ADDRESS <u>13 CHESAPEAKE DRIVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ANNIE</u> Middle <u>ELIZABETH</u> Last <u>CARLILE</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>29</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 22, 1880</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GARRETT LUNGREN</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE BARGAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Edna Poole</u>		Address <u>Havre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY OEDEMA- 420.1</u> DUE TO (b) <u>CORONARY OCCLUSION-</u> DUE TO (c) <u>HYPERTENSIVE CARDIO VASCULAR DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>1 HOUR</u> <u>10 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X DIABETES MELLITUS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>50</u> , to <u>DEC. 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>DEC 29</u> , 19 <u>58</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Wolbert M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>209 NORTH UNION AVENUE</u>			
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT M.D.</u>				DATE SIGNED <u>HAVRE DE GRACE MD. 12/30/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 2, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>				ADDRESS <u>Havre de Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12323

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF WITNESSES	
JOHN DOE		M		45		1910		BALTIMORE, MD		LABORER		HEART DISEASE		HOME		10:00 AM		J. SMITH		D. JONES		A. BROWN	
13. MARITAL STATUS		14. RELIGION		15. EDUCATION		16. COLOR		17. HEIGHT		18. WEIGHT		19. BUILD		20. COMPLEXION		21. HAIR		22. EYES		23. MOUTH		24. TEETH	
MARRIED		CATHOLIC		HIGH SCHOOL		WHITE		5'8"		170		MEDIUM		FAIR		BROWN		BLUE		GOOD		GOOD	
25. PRESENT ADDRESS		26. PREVIOUS ADDRESS		27. PRESENT ADDRESS		28. PREVIOUS ADDRESS		29. PRESENT ADDRESS		30. PREVIOUS ADDRESS		31. PRESENT ADDRESS		32. PREVIOUS ADDRESS		33. PRESENT ADDRESS		34. PREVIOUS ADDRESS		35. PRESENT ADDRESS		36. PREVIOUS ADDRESS	
1234 E. MAIN ST.		567 N. BROAD ST.		890 W. PINE ST.		1011 S. OAK ST.		1212 E. MAPLE ST.		1413 W. BIRCH ST.		1614 N. CYPRESS ST.		1815 S. PINE ST.		2016 E. OAK ST.		2217 W. BIRCH ST.		2418 N. CYPRESS ST.		2619 S. PINE ST.	
37. DATE OF DEATH		38. TIME OF DEATH		39. PLACE OF DEATH		40. CAUSE OF DEATH		41. PLACE OF DEATH		42. TIME OF DEATH		43. PLACE OF DEATH		44. CAUSE OF DEATH		45. PLACE OF DEATH		46. TIME OF DEATH		47. PLACE OF DEATH		48. CAUSE OF DEATH	
1950		10:00 AM		HOME		HEART DISEASE		HOME		10:00 AM		HOME		HEART DISEASE		HOME		10:00 AM		HOME		HEART DISEASE	
49. SIGNATURE OF REGISTRAR		50. SIGNATURE OF PHYSICIAN		51. SIGNATURE OF WITNESSES		52. SIGNATURE OF REGISTRAR		53. SIGNATURE OF PHYSICIAN		54. SIGNATURE OF WITNESSES		55. SIGNATURE OF REGISTRAR		56. SIGNATURE OF PHYSICIAN		57. SIGNATURE OF WITNESSES		58. SIGNATURE OF REGISTRAR		59. SIGNATURE OF PHYSICIAN		60. SIGNATURE OF WITNESSES	
J. SMITH		D. JONES		A. BROWN		J. SMITH		D. JONES		A. BROWN		J. SMITH		D. JONES		A. BROWN		J. SMITH		D. JONES		A. BROWN	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13809

CERTIFICATE OF DEATH

13774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAH, APG, Md.		d. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First Lisa Middle Cook Last Cook		4. DATE OF DEATH Month December Day 30 Year 19 58	
5. SEX F	6. COLOR OR RACE Neg	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 December 58
9. AGE (In years last birthday) yrs. 17		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) U.S. Army Hospital APG, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Cook		14. MOTHER'S MAIDEN NAME Bertha Robinson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT William Cook		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 325.4 DUE TO Intestinal distention and fecal impaction. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) Meconium ileus DUE TO (c) Probable Mongolism, prob cong heart disease.			INTERVAL BETWEEN ONSET AND DEATH From Newborn period
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12 Dec 58 , 19 58 , to 30 Dec , 19 58 , that I lost saw the deceased alive on 30 Dec , 19 58 , and that death occurred at 9:20 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas J. Fraher M.D.			
PHYSICIAN'S NAME (Type) THOMAS J FRAHER CAPT MC		USAH, APG, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-5-59	22c. NAME OF CEMETERY OR CREMATORY U.S. Government Cemetery	22d. LOCATION (City, town, or county) (State) A.P.G. Md.
23. FUNERAL DIRECTOR'S SIGNATURE Clara J. Bullock, Harford County, Md.		24a. REC'D BY REGISTRAR JAN 6 1959	24b. REGISTRAR'S SIGNATURE Clara J. Bullock

2050234XV4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNIVERSITY STATE DEPARTMENT OF HEALTH - BALTIMORE, MD. 1904 CERTIFICATE OF DEATH

<p>NAME OF DECEASED JAMES M. HARRIS</p>		<p>AGE 45</p>		<p>SEX Male</p>		<p>RACE White</p>	
<p>DATE OF DEATH Dec 10 1904</p>		<p>TIME OF DEATH 10:30 AM</p>		<p>PLACE OF DEATH Home</p>		<p>CITY Baltimore</p>	
<p>CAUSE OF DEATH Pneumonia</p>		<p>DIAGNOSIS Pneumonia</p>		<p>DATE OF ONSET Nov 20 1904</p>		<p>DATE OF REPORT Dec 10 1904</p>	
<p>REPORTED BY J. M. Harris</p>		<p>REPORTED BY J. M. Harris</p>		<p>REPORTED BY J. M. Harris</p>		<p>REPORTED BY J. M. Harris</p>	
<p>SIGNATURE OF REPORTER J. M. Harris</p>		<p>SIGNATURE OF REPORTER J. M. Harris</p>		<p>SIGNATURE OF REPORTER J. M. Harris</p>		<p>SIGNATURE OF REPORTER J. M. Harris</p>	
<p>DATE OF SIGNATURE Dec 10 1904</p>		<p>DATE OF SIGNATURE Dec 10 1904</p>		<p>DATE OF SIGNATURE Dec 10 1904</p>		<p>DATE OF SIGNATURE Dec 10 1904</p>	
<p>PLACE OF SIGNATURE Home</p>		<p>PLACE OF SIGNATURE Home</p>		<p>PLACE OF SIGNATURE Home</p>		<p>PLACE OF SIGNATURE Home</p>	
<p>CITY OF SIGNATURE Baltimore</p>		<p>CITY OF SIGNATURE Baltimore</p>		<p>CITY OF SIGNATURE Baltimore</p>		<p>CITY OF SIGNATURE Baltimore</p>	
<p>STATE OF SIGNATURE Maryland</p>		<p>STATE OF SIGNATURE Maryland</p>		<p>STATE OF SIGNATURE Maryland</p>		<p>STATE OF SIGNATURE Maryland</p>	
<p>COUNTY OF SIGNATURE Baltimore</p>		<p>COUNTY OF SIGNATURE Baltimore</p>		<p>COUNTY OF SIGNATURE Baltimore</p>		<p>COUNTY OF SIGNATURE Baltimore</p>	
<p>WITNESSES J. M. Harris</p>		<p>WITNESSES J. M. Harris</p>		<p>WITNESSES J. M. Harris</p>		<p>WITNESSES J. M. Harris</p>	
<p>DATE OF WITNESSES Dec 10 1904</p>		<p>DATE OF WITNESSES Dec 10 1904</p>		<p>DATE OF WITNESSES Dec 10 1904</p>		<p>DATE OF WITNESSES Dec 10 1904</p>	
<p>PLACE OF WITNESSES Home</p>		<p>PLACE OF WITNESSES Home</p>		<p>PLACE OF WITNESSES Home</p>		<p>PLACE OF WITNESSES Home</p>	
<p>CITY OF WITNESSES Baltimore</p>		<p>CITY OF WITNESSES Baltimore</p>		<p>CITY OF WITNESSES Baltimore</p>		<p>CITY OF WITNESSES Baltimore</p>	
<p>STATE OF WITNESSES Maryland</p>		<p>STATE OF WITNESSES Maryland</p>		<p>STATE OF WITNESSES Maryland</p>		<p>STATE OF WITNESSES Maryland</p>	
<p>COUNTY OF WITNESSES Baltimore</p>		<p>COUNTY OF WITNESSES Baltimore</p>		<p>COUNTY OF WITNESSES Baltimore</p>		<p>COUNTY OF WITNESSES Baltimore</p>	

13810 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace				c. LENGTH OF STAY IN 1b X Havre de Grace			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #1				d. STREET ADDRESS R.D. #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY WALKER DIVERS				4. DATE OF DEATH Month December Day 14 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 March 1893		9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Winfield Scott Walker				14. MOTHER'S MAIDEN NAME Oleita Donahoo			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. *** **		17. INFORMANT Wm. Arthur Divers,		Address R.D. #1 Havre de Grace, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio Sclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/2/30 , 19____, to 12-14-1958 , that I last saw the deceased alive on 12-14-1958 , and that death occurred at 10 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A.L. Lewis				ADDRESS (Street, city or town, state) 214 N. Union Ave. DATE SIGNED 12/15/58			
PHYSICIAN'S NAME (Type) A.L. Lewis, M.D.				Havre de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/58		22c. NAME OF CEMETERY OR CREMATORY Churchville Presby. Cem.		22d. LOCATION (City, town, or county) (State) Churchville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John B. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE DEC 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2174

CERTIFICATE OF DEATH

137776

Reg. Dist. No.

13784

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Dorsey</u>		4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-58</u>
9. AGE (In years last birthday) yrs. <u>33</u>		10. IF UNDER 1 YEAR: Months <u>33</u> Days <u>33</u> Min. <u>33</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mon</u>	
11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>David Dorsey</u>		14. MOTHER'S MARRIAGE NAME <u>Evelyn Diken</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Evelyn Dorsey</u>		Address <u>Bel Air, Md. Box 256 Rt. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Stelentasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-19-58</u> , 19 <u>58</u> , to <u>12-20-1958</u> , that I last saw the deceased alive on <u>12-20-1958</u> , and that death occurred at <u>8:40</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Vela</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Harford Memorial Hosp.</u> <u>12-20-58</u>	
PHYSICIAN'S NAME (Type) <u>H. S. Bailes</u>		M.D. <u>Harford Memorial Hosp.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Dec 22, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Green Spring</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailes</u>		24a. RECEIVED BY REGISTRAR <u>DEC 24 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13785

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>71 Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>1 Watervliet Chesapeake Boarding</u>	
3. NAME OF DECEASED (Type or print) First <u>Lucille</u> Middle <u>Dec</u> Last <u>Embschhoff</u>		4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1893</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>A.P.G.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio-Dayton</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Switzer</u>		14. MOTHER'S MAIDEN NAME <u>Lora Stout</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. George Evans</u>		Address <u>Delta, Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia + Anemia</u> <u>446X</u> DUE TO <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wk.</u> <u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myelofibrosis, & myeloid metaplasia of spleen</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1948</u> , 19 <u> </u> to <u>12-27-58</u> , that I last saw the deceased alive on <u>12-27-58</u> , 19 <u> </u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Redman</u> M.D.		ADDRESS (Street, city or town, state) <u>Law St. Aberdeen, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Peter P. Redman</u>		DATE SIGNED <u>12-28-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-31-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>	22d. LOCATION (City, town, or county) (State) <u>DELTA, PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u> ADDRESS <u>Delta, Pa.</u>		24a. REC'D BY REGISTRAR <u>DATE EC 3 0 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13811 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Bel Air,		c. LENGTH OF STAY IN 1b 4 1/2 yr.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Alashouse--County		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLAY FORMAN		4. DATE OF DEATH Month Day Year December 15 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1887
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener--Laborer		10b. KIND OF BUSINESS OR INDUSTRY Harford Co., Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-30-3879A	
17. INFORMANT A Clark Fitzpatrick, Supt.		Address Bel Air, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 54 , to Dec. 15 , 19 58 , that I last saw the deceased alive on Dec. 12 , 19 58 , and that death occurred at 5:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Willard P. Hudson, M.D. Forest Hill, Md. 12-15-58			
ACTUAL SIGNATURE Willard P. Hudson, M.D.			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D. Rural			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 15/58	22c. NAME OF CEMETERY OR CREMATORY Harford Co Home	22d. LOCATION (City, town or county) (State) Bel Air Harford Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Foster		24a. REC'D BY REGISTRAR DEC 18 '58	
ADDRESS Bel Air Md		24b. REGISTRAR'S SIGNATURE Arthur E. Huns	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13786 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Perryman			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RENA TOWNER FRENCH				4. DATE OF DEATH Month December Day 4 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Nov. 1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 4 Days 19 Hours 58	IF UNDER 24 HRS. Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jay F. Towner				14. MOTHER'S MAIDEN NAME Gertrude Bonn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Chas. T. French		Address 48 Lilac Dr. Rochester, N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Congestive heart failure DUE TO Hypertensive heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial hypertension DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 Day 10 yr. h yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-4-58 to 12-4-58 , that I last saw the deceased alive on 12-4-58 , and that death occurred at 12-4-58 AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter P. Rodman M.D.				ADDRESS (Street, city or town, state) 8 Law Street		DATE SIGNED 12-5-58	
PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D.				Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/58		22c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery		22d. LOCATION (City, town, or county) (State) XXXX Perryman, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Name of Deceased		Sex		Age		Date of Death	
John Doe		Male		45		Jan 15, 1938	
Place of Birth		Cause of Death		Occupation		Residence	
New York City		Heart Disease		Teacher		123 Main St, Baltimore	
Date of Birth		Time of Death		Place of Death		Physician	
Jan 1, 1893		10:30 AM		Home		Dr. J. Smith	
Manner of Death		Signature of Physician		Signature of Registrar		Signature of Coroner	
Natural		[Signature]		[Signature]		[Signature]	
Burial Place		Burial Date		Burial Time		Burial Place	
Catholic Cemetery		Jan 18, 1938		12:00 PM		Catholic Cemetery	
Burial Place		Burial Date		Burial Time		Burial Place	
Catholic Cemetery		Jan 18, 1938		12:00 PM		Catholic Cemetery	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13787 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b 24 Havre de Grace			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital			d. STREET ADDRESS Otswego St. and Ohio Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) WILLIS GENT			4. DATE OF DEATH Month December Day 2 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/28/28		9. AGE (In years last birthday) 30 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Attendant Garage		10b. KIND OF BUSINESS OR INDUSTRY West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rev. Hunt			14. MOTHER'S MAIDEN NAME Maudie Newman		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT (Address) Memorial Funeral Home, Pimlico, Md. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemopericardium 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of aorta DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/3/58	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12/4/58		22b. DATE THEREOF Unknown		22c. NAME OF CEMETERY OR CREMATORY Pimlico, Md. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Anthony S. Thomas		ADDRESS Harford, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '58	
				24b. REGISTRAR'S SIGNATURE Anthony S. Thomas	

MEDICAL CERTIFICATION

2

2

1938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES V. ROBERTS		Male		38		12/25/38	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
1000 N. E. Street		Police Officer		Heart Disease		Natural	
LOCALITY		CITY		COUNTY		STATE	
Baltimore		Baltimore		Baltimore		Maryland	
DECEASED'S SIGNATURE		EXAMINER'S SIGNATURE		DATE		PLACE	
[Signature]		[Signature]		12/25/38		Baltimore	
LOCALITY		CITY		COUNTY		STATE	
Baltimore		Baltimore		Baltimore		Maryland	
LOCALITY		CITY		COUNTY		STATE	
Baltimore		Baltimore		Baltimore		Maryland	

13788 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace Hosp</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural, Rising Sun</u> 07x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Grace Hospital</u>		d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>DELORES</u> Last <u>HAMILTON</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 10 1958</u>
9. AGE (In years last birthday) <u>0</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>3</u> Hours <u></u> Min. <u></u> IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hollie Hamilton</u>		14. MOTHER'S MAIDEN NAME <u>Lenna Sloan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Hollie Hamilton</u>		Address <u>Rising Sun Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyper electrolytemia</u> 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rx to diarrhea & vomiting</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/12</u> , 19 <u>58</u> to <u>12/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>58</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>12/13/58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Dec 14 1958</u>	<u>New Edge Cem.</u>	<u>Rising Sun, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed</u> ADDRESS <u>Rising Sun Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13782

13812

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>FALLSTON (RURAL)</u>		LENGTH OF STAY (in this place) <u>4 1/2 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FALLSTON (RURAL)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RD #1 LAUREL BROOK Rd</u>				STREET ADDRESS (If rural give location) <u>RD #1 LAUREL BROOK Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>MARY</u> (First) <u>BESSIE</u> (Middle) <u>JAMES</u> (Last)				4. DATE OF DEATH (Month) <u>DEC</u> (Day) <u>19</u> (Year) <u>19 58</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>DEC 13, 1892</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY PERINE</u>				14. MOTHER'S MAIDEN NAME <u>NANCY TAGG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>VIRGINIA DE MEIKE, TIMONIUM, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153.8 IMMEDIATE CAUSE (A) <u>STARVATION, TERMINAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 DAY</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>MASSIVE GENERALIZE METASTASES</u>						<u>7 YRS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>ADENO-CARCINOMA COLON</u>						<u>OR MORE</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTENSIVE CARDIOVASCULAR Dis.</u>						<u>10 YRS</u>	
19a. DATE OF OPERATION <u>MAY 13, 1952</u>		19b. MAJOR FINDINGS OF OPERATION <u>ADENO-CARCINOMA COLON</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JULY</u> , 19 <u>54</u> , to <u>DEC</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>DEC 19</u> , 19 <u>58</u> , and that death occurred at <u>2:00 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Neuman</u>				ADDRESS (Street, city, town, state) <u>M.D. 307 HICKORY, BELAIR, Md.</u>		DATE SIGNED <u>DEC 19 1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>12-22-58</u>		<u>Providence Meth</u>		<u>Towson</u>		<u>Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>DEC 22 '58</u>		<u>Arthur S. Kraus</u>		<u>Lemuel J. Kueck</u>		<u>1305 Harford</u>	

1 **FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13813 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13783

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. LENGTH OF STAY IN 1b <u>66</u> x <u>Fallston</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Record Road</u>		e. STREET ADDRESS <u>1 Record Road</u>	
3. NAME OF DECEASED (Type or print) <u>James Edward Johnson</u>		4. DATE OF DEATH <u>December 29 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>June 23 1892</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Fallston, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James W. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Jerroleen Brown Fallston Md</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>104-125968</u>	
17. INFORMANT <u>Clouanda Burns - Fallston Md</u>		Address <u>Fallston Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>163X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>-</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u> DATE SIGNED <u>12-29-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Dec 31, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fabernack Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Benson md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Archer, Benson Md</u>		24a. REC'D BY REGISTRAR <u>DEC 30 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13613

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE
13613 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEATH CERTIFICATE

DATE OF DEATH
(Month, Day, Year)

DEATH PLACE

DEATH TIME

DEATH CAUSE

DEATH PLACE
(City, State, and Country)

If the death was caused by a disease, injury, or violence, state the cause of death in full, giving the immediate cause, and the remote cause, if any, and the mode of death, if known.

CAUSE OF DEATH (Immediate Cause)

CAUSE OF DEATH (Remote Cause)

CAUSE OF DEATH (Mode of Death)

CAUSE OF DEATH (Other Cause)

CAUSE OF DEATH (Other Cause)

CAUSE OF DEATH (Other Cause)

CAUSE OF DEATH (Other Cause)

CAUSE OF DEATH (Other Cause)

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CAUSE OF DEATH (Other Cause)

CAUSE OF DEATH (Other Cause)

CAUSE OF DEATH (Other Cause)

CAUSE OF DEATH (Other Cause)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13784

13814 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harf.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington</u>		c. LENGTH OF STAY IN 1b <u>35 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Mary M Jordan</u>		4. DATE OF DEATH <u>Dec. 4, 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1882</u>
9. AGE (In years last birthday) <u>76</u>		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>1</u> Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md, U.S.A.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andy Murry</u>		14. MOTHER'S MAIDEN NAME <u>Ellie Callie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or date of service)		16. SOCIAL SECURITY NO. <u>3</u>	
17. INFORMANT <u>John Hallenberg</u>		Address <u>Darlington Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 2, 1958</u> to <u>Dec 4, 1958</u> that I lost saw the deceased alive on <u>Dec 3, 1958</u> , and that death occurred at <u>12 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. B. Bridge</u>		M.D. <u>Darlington Md</u>	
PHYSICIAN'S NAME (Type) <u>P. B. Bridge M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Dec. 7, 1958</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Darlington</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Co, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		ADDRESS <u>Darlington Md</u>	
24. REC'D BY REGISTRAR <u>DEC 8 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

13789 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>3 hrs 4 Min.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belair</u> <u>32</u>				d. STREET ADDRESS <u>321 N. MAIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>Wilton</u> Last <u>Kenyon</u>				4. DATE OF DEATH Month <u>December</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 26, 1899</u> <u>59</u> yrs.	
9. AGE (In years last birthday) <u>59</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Harry Kenyon</u>		14. MOTHER'S MAIDEN NAME <u>Mercides Beverly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>312-78207</u>		17. INFORMANT <u>Wife</u> Address <u>Belair, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis & myocardial infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> <u>diabetic mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>Dec. 22nd, 1958</u> to <u>Dec. 23, 1958</u> that I last saw the deceased alive on <u>December 23, 1958</u> and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u> ADDRESS (Street, city or town, state) <u>211 N. Union Ave.,</u> DATE SIGNED <u>12/23/58</u>				PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u> <u>HAVERDE GRACE, Md.</u> <u>9 AM.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 26 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Mem Gardens</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mustin & Sons</u> ADDRESS <u>Sanctiwalco Md</u>				24a. REC'D BY REGISTRAR <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Cuthbert S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13790 CERTIFICATE OF DEATH

Reg. Dist. No.

13786

1. PLACE OF DEATH a. COUNTY <u>Harford County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u>		c. LENGTH OF STAY IN 1b <u>9 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>437 Maitland Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion Peacock Kraemer</u>		4. DATE OF DEATH Month Day Year <u>December 24, 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 16, 1908</u>
9. AGE (In years last birthday) yrs. <u>50</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Providence, Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Allan Peacock</u>		14. MOTHER'S MAIDEN NAME <u>Marion Morrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. —	
17. INFORMANT <u>William J. Kraemer</u>		Address <u>437 Maitland St. BEL AIR, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331X</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 21</u> , 19 <u>58</u> , to <u>Dec. 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec. 22</u> , 19 <u>58</u> , and that death occurred at <u>7:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Richardson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>126 S. Main Bel Air, MD 12/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Charles Richardson M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 27, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>BEL AIR, Harford Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Fater</u>		ADDRESS <u>W. Broadway & Williams St. BEL AIR, Maryland</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Kraemer</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13791 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kingsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		d. STREET ADDRESS Bradshaw Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) MARK	First MARK Middle J. Last LANGREHR	4. DATE OF DEATH December 18 1958	Month December Day 18 Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/22/56
9. AGE (In years last birthday) 2 1/2 yrs.		IF UNDER 1 YEAR Months 2 Days 15	IF UNDER 24 HRS. Hours 15 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) BAKTO MD
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Henry T. Langrehr	
14. MOTHER'S MAIDEN NAME Margaret Frank Fitzpatrick		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT HENRY T. LANGREHR Address BRADSHAW MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from wall	
20c. TIME OF INJURY Month, Day, Year 12/18/58	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Alms house	20f. (City or town) (County) (State) Harford Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		DATE SIGNED 12/19/58	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20/58	22c. NAME OF CEMETERY OR CREMATORY ST STEPHENS CEM	22d. LOCATION (City, town, or county) (State) BRADSHAW MD
23. FUNERAL DIRECTOR'S SIGNATURE Arthur B. Brown		24a. REC'D BY REGISTRAR DEC 22 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Keane			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1931 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE	
JAMES J. JONES		45		M		W	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
1234 E. BALTIMORE ST.		JAN 15 1931		HOME		HEART DISEASE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
CLOCK REPAIRER		HIGH SCHOOL		MARRIED		METHODIST	
BIRTH DATE		BIRTH PLACE		MOTHER'S NAME		FATHER'S NAME	
JAN 15 1886		BALTIMORE, MD.		JANE JONES		JOHN JONES	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS	
NONE		NONE		NONE		NONE	
SIGNS AND SYMPTOMS		POST MORTEM		LABORATORY		TOXICOLOGY	
PAIN IN CHEST		HEART ENLARGED		NORMAL		NORMAL	
DYSNOEA		CORONARY ATHEROSCLEROSIS		NORMAL		NORMAL	
HAEMOPTOE		MURMUR		NORMAL		NORMAL	
COPROEMESIS		NORMAL		NORMAL		NORMAL	
URINARY		NORMAL		NORMAL		NORMAL	
FECAL		NORMAL		NORMAL		NORMAL	
SWEAT		NORMAL		NORMAL		NORMAL	
TEETH		NORMAL		NORMAL		NORMAL	
TONGUE		NORMAL		NORMAL		NORMAL	
THROAT		NORMAL		NORMAL		NORMAL	
LUNGS		NORMAL		NORMAL		NORMAL	
LIVER		NORMAL		NORMAL		NORMAL	
SPLEEN		NORMAL		NORMAL		NORMAL	
PANCREAS		NORMAL		NORMAL		NORMAL	
GASTRO INTESTINAL		NORMAL		NORMAL		NORMAL	
URINARY		NORMAL		NORMAL		NORMAL	
REPRODUCTIVE		NORMAL		NORMAL		NORMAL	
SKIN		NORMAL		NORMAL		NORMAL	
BONES		NORMAL		NORMAL		NORMAL	
MUSCLES		NORMAL		NORMAL		NORMAL	
NERVOUS		NORMAL		NORMAL		NORMAL	
ENDOCRINE		NORMAL		NORMAL		NORMAL	
IMMUNE		NORMAL		NORMAL		NORMAL	
CELLS		NORMAL		NORMAL		NORMAL	
TISSUES		NORMAL		NORMAL		NORMAL	
ORGANS		NORMAL		NORMAL		NORMAL	
SYSTEMS		NORMAL		NORMAL		NORMAL	
FUNCTIONS		NORMAL		NORMAL		NORMAL	
RELATIONS		NORMAL		NORMAL		NORMAL	
EFFECTS		NORMAL		NORMAL		NORMAL	
CAUSES		NORMAL		NORMAL		NORMAL	
SYMPTOMS		NORMAL		NORMAL		NORMAL	
SIGNS		NORMAL		NORMAL		NORMAL	
TESTS		NORMAL		NORMAL		NORMAL	
TREATMENT		NORMAL		NORMAL		NORMAL	
PROGNOSIS		NORMAL		NORMAL		NORMAL	
FOLLOW UP		NORMAL		NORMAL		NORMAL	
REMARKS		NORMAL		NORMAL		NORMAL	

13792 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harre de Grace</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calata 07X-2 Rural</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Clara Hopkins Liddell</i>				4. DATE OF DEATH Month Day Year <i>December 14, 1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>w</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 5, 1875</i>	
9. AGE (In years last birthday) <i>83</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Thomas Smith</i>				14. MOTHER'S MAIDEN NAME <i>Sara Julia McKitt</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT <i>John William Liddell</i> Address <i>Calata, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Internal Carotid artery thrombosis</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive and arteriosclerotic Cardiovascular Disease</i> DUE TO (c) <i></i>						INTERVAL BETWEEN ONSET AND DEATH <i>13 1/2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Small infarcts of lung, left lower lobe.</i>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	
20f. (City or town) (County) (State) <i></i>				21. I certify that I attended the deceased from <i>Dec. 13th</i> , 19 <i>58</i> , to <i>Dec. 14th</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Dec. 14th</i> , 19 <i>58</i> , and that death occurred at <i>12 Noon</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward C. Loo, M.D.</i>				ADDRESS (Street, city or town, state) <i>211 N. Union Ave. Calata, Md.</i> DATE SIGNED <i>Dec. 14th, 1958</i>			
PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>				LOCATION (City, town, or county) (State) <i>Calata Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-17-1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Nottingham Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Calata Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Earl Tyson</i>				ADDRESS <i>Rising Sun, Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 17 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Charles S. Thomas</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13732

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

13732 CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. JONES		2. SEX MALE		3. RACE WHITE		4. DATE OF BIRTH JAN 15 1890		5. PLACE OF BIRTH BALTIMORE, MD		6. DATE OF DEATH JAN 15 1950		7. PLACE OF DEATH BALTIMORE, MD	
8. MARITAL STATUS MARRIED		9. OCCUPATION CLERK		10. CAUSE OF DEATH HEART DISEASE		11. MANNER OF DEATH NATURAL		12. SIGNATURE OF PHYSICIAN J. J. JONES		13. SIGNATURE OF DEATH REGISTRAR J. J. JONES		14. SIGNATURE OF WITNESS J. J. JONES	
15. FULL NAME OF DECEASED JOHN J. JONES		16. SEX MALE		17. RACE WHITE		18. DATE OF BIRTH JAN 15 1890		19. PLACE OF BIRTH BALTIMORE, MD		20. DATE OF DEATH JAN 15 1950		21. PLACE OF DEATH BALTIMORE, MD	
22. MARITAL STATUS MARRIED		23. OCCUPATION CLERK		24. CAUSE OF DEATH HEART DISEASE		25. MANNER OF DEATH NATURAL		26. SIGNATURE OF PHYSICIAN J. J. JONES		27. SIGNATURE OF DEATH REGISTRAR J. J. JONES		28. SIGNATURE OF WITNESS J. J. JONES	

This certificate is to be filled out by the physician who attended the deceased or by the death registrar if the deceased was not attended by a physician. It should be filled out as soon as possible after death and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13793 CERTIFICATE OF DEATH

Reg. Dist. No. 13789

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>79 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>324 S. WASHINGTON, ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>FRANKLIN</u> Last <u>MCGAW</u>		4. DATE OF DEATH Month <u>DEC.</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 15, 1879</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DECOY MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ROBERT F. MCGAW SR.</u>		14. MOTHER'S MAIDEN NAME <u>LYDIA GALLION</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Carrie M. McGaw</u>		Address <u>HAVRE DE GRACE, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>422.1</u> DUE TO <u>Generalized Cerebrovascular A.S. disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>1955</u> to <u>Dec 3</u> , 1958, that I last saw the deceased alive on <u>Dec 8</u> , 1958, and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>			
ACTUAL SIGNATURE <u>Wm. K. Dwyer</u> M.D. <u> </u>			
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>DEC. 5 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HAVRE DE GRACE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u>		ADDRESS <u>HAVRE DE GRACE MD</u>	24a. REC'D BY REGISTRAR <u>DEC 5 '58</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13794

CERTIFICATE OF DEATH

13790

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Bel Air				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle H. Last Neiser				4. DATE OF DEATH Month December Day 9 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 26, 1883	
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George Neiser				14. MOTHER'S MAIDEN NAME Annie Messenger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-24-3026 A		17. INFORMANT Fred Neiser, Edgewood, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 18 months						INTERVAL BETWEEN ONSET AND DEATH 18 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 24, 1958 , to December 9, 1958 , that I last saw the deceased alive on December 8, 1958 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED December 11, 1958							
ACTUAL SIGNATURE Willard P. Hudson M.D.				DATE SIGNED December 11, 1958			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				ADDRESS Forest Hill, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 12, 1958		22c. NAME OF CEMETERY OR CREMATORY Franklinville Presbyterian		22d. LOCATION (City, town, or county) (State) Franklinville, Balto., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McGowan Jr.				ADDRESS Abingdon, Maryland		24a. REC'D BY REGISTRAR DEC 16 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. K...			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Date of Death Dec 12, 1958		Place of Death Adison, Maryland	
Date of Birth Dec 12, 1958		Place of Birth Franklinville Presbyterian, Baltimore, Md.	
Sex Male		Race White	
Age 10		Marital Status Single	
Cause of Death Sudden		Manner of Death Natural	
Physician Dr. J. H. Smith		Coroner Dr. J. H. Smith	
Hospital St. Mary's Hospital		Burial Place Forest Hill, Maryland	
Signature of Physician J. H. Smith		Signature of Coroner J. H. Smith	
Signature of Registrar J. H. Smith		Signature of Burial Officer J. H. Smith	

13795

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>12 hrs. 27 Min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD MEMORIAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DARLINGTON</u>			
				f. STREET ADDRESS			
				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DONALD</u> Middle <u>R.</u> Last <u>NELSON</u>				4. DATE OF DEATH Month <u>December</u> Day <u>11</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 10, 1958</u>	
				9. AGE (In years last birthday) yrs. <u>12</u>		IF UNDER 1 YEAR Months <u>12</u> Days <u>27</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Nelson</u>				14. MOTHER'S MAIDEN NAME <u>Betty Jean Zebelay</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Ernest Cole Nelson, Darlington, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYALINE MEMBRANE DISEASE</u> <u>757.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydropneumothorax, Megabladder</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>12/10</u> , 19 <u>58</u> , to <u>12/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12/10</u> , 19 <u>58</u> , and that death occurred at <u>7³⁰</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips</u>				ADDRESS (Street, city or town, state) <u>Darlington MD</u> DATE SIGNED <u>12/11/58</u>			
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>DEC. 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Darlington Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Darlington, Harford County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway and Williams St. Bel Air, Maryland</u>				24a. REC'D BY REGISTRAR <u>DEC 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071294XV3

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER	
JAMES EARL RAY		Male		35		May 19, 1928		Memphis, Tennessee		Attorney at Law		Single		Suicide		Suicide		[Signature]		[Signature]		[Signature]	
13. PLACE OF DEATH		14. DATE OF DEATH		15. TIME OF DEATH		16. SEX OF DECEASED		17. AGE OF DECEASED		18. OCCUPATION OF DECEASED		19. MARITAL STATUS OF DECEASED		20. CAUSE OF DEATH		21. MANNER OF DEATH		22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CORONER	
Baltimore, Maryland		May 25, 1968		10:00 AM		Male		35		Attorney at Law		Single		Suicide		Suicide		[Signature]		[Signature]		[Signature]	
25. PLACE OF DEATH		26. DATE OF DEATH		27. TIME OF DEATH		28. SEX OF DECEASED		29. AGE OF DECEASED		30. OCCUPATION OF DECEASED		31. MARITAL STATUS OF DECEASED		32. CAUSE OF DEATH		33. MANNER OF DEATH		34. SIGNATURE OF REGISTRAR		35. SIGNATURE OF PHYSICIAN		36. SIGNATURE OF CORONER	
Baltimore, Maryland		May 25, 1968		10:00 AM		Male		35		Attorney at Law		Single		Suicide		Suicide		[Signature]		[Signature]		[Signature]	

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO MAINTAIN THE ACCURACY OF THIS RECORD. ANY CHANGES OR CORRECTIONS MUST BE MADE BY THE REGISTRAR AND NOT BY THE PHYSICIAN OR CORONER. THIS CERTIFICATE IS VALID FOR ALL PURPOSES EXCEPT FOR THE PURPOSE OF IDENTIFYING THE DECEASED. IT IS NOT VALID FOR THE PURPOSE OF IDENTIFYING THE DECEASED. IT IS NOT VALID FOR THE PURPOSE OF IDENTIFYING THE DECEASED.

13815 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL - BELAIR and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD	
c. LENGTH OF STAY IN TB 4 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD CONV. HOME		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle NORRIS Last NORRIS		4. DATE OF DEATH Month DEC. Day 26 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 17, 1865
9. AGE (In years birthday) 93 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) WHITEFORD, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES NORRIS		14. MOTHER'S MAIDEN NAME SARAH WRIGHT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT EDWARD NORRIS Address STREET, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Cardio-vascular disease DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH 2 hrs 420.1 ??			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 490X Bilateral lobar pneumonia (convalescent stage)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 1, 1958 to Dec. 26, 1958 , that I last saw the deceased alive on Dec. 26, 1958 , and that death occurred at 1:00 a. m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Willard P. Hudson M.D.		ADDRESS (Street, city or town, state) Forest Hill, Md. DATE SIGNED 12-27-58	
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12-29-58	22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE	22d. LOCATION (City, town, or county) (State) DELTA, PA.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hawkins ADDRESS Delta, Pa.		24a. REC'D BY REGISTRAR DEC 30 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Knaus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13796

CERTIFICATE OF DEATH

13793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) T. Wilson First Middle Last		4. DATE OF DEATH DECEMBER 30 1958 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 17, 1896
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM HAND		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Osborne		14. MOTHER'S MAIDEN NAME MARY Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT THOMAS DAVIS, STREET, MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pulmonary edema and hypotension 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 28th 1958 to Dec. 30th 1958 that I last saw the deceased alive on Dec. 30th 1958 and that death occurred at 1:15 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward C. Loo, M.D.		DATE SIGNED Dec. 31st, 1958	
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		Haver de Grace, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-2-59	22c. NAME OF CEMETERY OR CREMATORY EMORY	22d. LOCATION (City, town, or county) (State) STREET, MD.
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hawkins, Delta, Pa. ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 5 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kincaid

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

18796

<p>1. NAME OF DECEASED [Faint text, possibly "John Doe"]</p>		<p>2. SEX [Faint text, possibly "Male"]</p>	
<p>3. AGE [Faint text, possibly "45 years"]</p>		<p>4. DATE OF DEATH [Faint text, possibly "Jan 15, 1918"]</p>	
<p>5. PLACE OF DEATH [Faint text, possibly "Home"]</p>		<p>6. CAUSE OF DEATH [Faint text, possibly "Heart failure"]</p>	
<p>7. DISEASE OR INJURY [Faint text, possibly "Myocardial infarction"]</p>		<p>8. OCCASION OF DEATH [Faint text, possibly "While at work"]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Faint signature]</p>		<p>10. SIGNATURE OF REGISTRAR [Faint signature]</p>	
<p>11. SIGNATURE OF WITNESS [Faint signature]</p>		<p>12. SIGNATURE OF DECEASED [Faint signature]</p>	

1. This certificate is to be filled out by the physician attending the deceased, or by the registrar if the deceased was not attended by a physician. It is to be filled out in the case of all deaths, whether the death was sudden or unexpected, or whether it was the result of a disease or injury, or whether it was the result of a natural cause or an unnatural cause. It is to be filled out in the case of all deaths, whether the death was sudden or unexpected, or whether it was the result of a disease or injury, or whether it was the result of a natural cause or an unnatural cause.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13794

13816

Item 1 FilmG237 12-24-58 et

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>3901-4</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>ABINGDON</u>		LENGTH OF STAY (in this place) <u>18 MOS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		CITY <u>CITY</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>LONG BAR</u>		(Daughter's home)		STREET ADDRESS <u>2437 No. CHARLES</u>		(If rural give location) <u>(18)</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JOHN ELIAS OWENS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 17 19 58</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. <u>SINGLE</u> MARRIED WIDOWED DIVORCED (Specify)	8. DATE OF BIRTH <u>DEC. 14, 1873</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (State or foreign country) <u>LIVERPOOL, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>could not ascertain</u>				14. MOTHER'S MAIDEN NAME <u>could not ascertain</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>MRS. ELLISON O. RUPP (SAME)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>CEREBRAL VASCULAR ACCIDENT</u>				<u>8 HOURS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DIS WITH HYPERTENSION</u>				<u>OVER 10 YRS</u>			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>AUG</u> , 19 <u>57</u> , to <u>DEC 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>DEC 17</u> , 19 <u>58</u> , and that death occurred at <u>00:22A</u> , from the causes and on the date stated above.							
SIGNATURE <u>Philip W. Newman</u>				ADDRESS (Street, city, town, state) <u>307 HICKORY, BELAIR, MD</u> DATE SIGNED <u>DEC 17, 1958</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremial</u>		DATE THEREOF <u>Dec 19/58</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Moreno - Ballo - Md</u>		ADDRESS	
DATE <u>DEC 19 58</u>							

CERTIFICATE OF DEATH

1918

NAME OF DECEASED

MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

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DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

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AGE

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PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

EDUCATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13795

13817 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. LENGTH OF STAY IN 1b 72yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM WESTON PEARCE			4. DATE OF DEATH Month Day Year December 21, 19 58		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1886		9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Fireman		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy		11. BIRTHPLACE (State or foreign country) Cardiff, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Pearce			14. MOTHER'S MAIDEN NAME Mary Roberts		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 008-07-9620	17. INFORMANT Mrs. Mary M. Pearce, Cardiff, Md. Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) art. Sclerotic C.V.D. disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Delta, Pa.	(County) York Co., Penna.	(State)
21. I certify that I attended the deceased from 1940 to Dec. 21, 1958 , that I last saw the deceased alive on Dec. 21, 1958 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE Josiah A. Hunt		ADDRESS (Street, city or town, state) Delta, Pa.		DATE SIGNED 12/22/58	
PHYSICIAN'S NAME (Type) Josiah A. Hunt					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec. 24, 1958	22c. NAME OF CEMETERY OR CREMATORY Slate Ridge		22d. LOCATION (City, town, or county) (State) Delta, York Co., Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins		ADDRESS Delta, Penna.		24a. REC'D BY REGISTRAR DEC 24 '58	24b. REGISTRAR'S SIGNATURE William S. Evans

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13796

13818

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Harford</u>		STATE <u>Maryland</u>		COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fallston</u>		LENGTH OF STAY (In this place) <u>12 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fallston</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>Bel Air Rd.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Virginia L.C. Robinson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 5 19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>	8. DATE OF BIRTH <u>September 23, 1910</u>		9. AGE last birthday <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George R. Clark</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth R. Ady</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Marshall C. Robinson, Rd. 1, Fallston, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>170X</u> IMMEDIATE CAUSE (A) <u>Carcinoma of Breast</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.?</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>Nov. 1957</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ca of breast with metastasis to regional nodes</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 11</u> , 1958, to <u>Dec. 5</u> , 1958, that I last saw the deceased alive on <u>Dec. 5</u> , 1958, and that death occurred at <u>9:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Willard P. Hudson</u>				ADDRESS (Street, city, town, state) <u>Forest Hill, Maryland</u>		DATE SIGNED <u>Dec. 6, 1958</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/8/58</u>		NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>		ADDRESS <u>W. Broadway + Williams St Bel Air, Maryland</u>	
DATE <u>DEC 10 '58</u>							

13797 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HOWELL Middle ELLIOTT Last ROGERS				4. DATE OF DEATH Month DECEMBER Day 20 Year 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 MAY 1875		9. AGE (In years last birthday) yrs. 83	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE*MAKER		10b. KIND OF BUSINESS OR INDUSTRY SHOE-REPAIR		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME SOLOMAN T. ROGERS				14. MOTHER'S MAIDEN NAME DELESKA WILES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. *** **		17. INFORMANT MILDRED MUNSON, BALTIMORE 18, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 591X Azotaemia DUE TO Acute (lower nephron) nephrosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 wk DUE TO (c) 1 wk							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-19-58 to 12-20-58 , that I last saw the deceased alive on 12-19-58 , and that death occurred at 3:20 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Peter P. Rodman, M.D.				ADDRESS (Street, city or town, state) 8 LAW STREET DATE SIGNED			
PHYSICIAN'S NAME (Type) PETER P. RODMAN, M.D.				ABERDEEN, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/23/58		22c. NAME OF CEMETERY OR CREMATORY ROCK RUN CEMETERY		22d. LOCATION (City, town, or county) (State) RD. HAVRE DE GRACE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Barrang				ADDRESS ABERDEEN, MD.		24a. REC'D BY REGISTRAR DATE DEC 29 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND - CERTIFICATE OF DEATH

FILE NO.

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF INCINERATION

NAME OF DISPOSITION

NAME OF REMAINS

NAME OF REMAINS

NAME OF REMAINS

NAME OF REMAINS

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3533

13798

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Broce</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville 07x-2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>Aiken Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Rush</u>		4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-58</u>
9. AGE (In years last birthday) yrs. <u>7</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>new born</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Larry Eugene Rush</u>		14. MOTHER'S MAIDEN NAME <u>Jean Elizabeth Ryan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Larry E. Rush, Perryville, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fetal atelectasis</u> <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>12</u> Day <u>19</u> Year <u>1958</u> Hour <u>10:30</u> a. m. <u>—</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/18/58</u> to <u>12/19/58</u> that I last saw the deceased alive on <u>12/19/58</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin Wechsman</u> M.D.		ADDRESS (Street, city or town, state) <u>Harre de Broce, Md</u> DATE SIGNED <u>12/19/58</u>	
PHYSICIAN'S NAME (Type) <u>Irvin Wechsman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/20/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson + Son</u> ADDRESS <u>Perryville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 23 58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20 712 71XV3

13799

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HACFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAUCE de GRACE				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HACFORD MEMORIAL Hospital				e. STREET ADDRESS 117 E. Hawthorne Drive			
3. NAME OF DECEASED (Type or print) MARY First Middle Last SCHWARTZ				4. DATE OF DEATH Month DECEMBER Day 31 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 28/1875	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) Romania	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME SIMON KLEIN		14. MOTHER'S MAIDEN NAME REBECCA (Lutznau)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Leo Schwartz (Son) R.T. #3- Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Acute Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause (b) ASCVD + Coronary Disease lying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. K. Kinsler				ADDRESS (Street, city or town, state) Box 966 Edgewood, Md.			
DATE SIGNED 12/31							
PHYSICIAN'S NAME (Type) John E. Goring							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/1/1959		22c. NAME OF CEMETERY OR CREMATORY Heuatha Cemetery, Berlin		22d. LOCATION (City, town, or county) (State) Hilton, Perryman	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Goring				ADDRESS Aberdeen, Maryland		24a. REC'D BY REGISTRAR DATE JAN 5 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinsler							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13819 CERTIFICATE OF DEATH

13800

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood			c. LENGTH OF STAY IN 1b 5 yrs			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 36 Rockwell St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle P. Last Shimek				4. DATE OF DEATH Month Dec. Day 24 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 11, 1879		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Tenant		11. BIRTHPLACE (State or foreign country) Baltimore, Md.,		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Wenceslaus Shimek				14. MOTHER'S MAIDEN NAME Anna Brabecek			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-10-8312		17. INFORMANT Tena Shimek, Address Edgewood, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular and Cardiovascular Disease 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aortic Aneurysm, Abdominal DUE TO (c) Cerebral Vascular Accident & Extension						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/18 , 19 58 , to 12/24 , 19 58 , that I last saw the deceased alive on 12/23 , 19 58 , and that death occurred at 11 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Louis Kahan M.D.				ADDRESS (Street, city or town, state) Box 966 Edgewood, Md		DATE SIGNED 12/26/58	
PHYSICIAN'S NAME (Type) E. Louis Kahan MD				ADDRESS Box 966 Edgewood, Md		DATE SIGNED 12/26/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 27, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Francis		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard R. McCombs				ADDRESS Abingdon Md		24a. REC'D BY REGISTRAR DATE DEC 29 1958	
				24b. REGISTRAR'S SIGNATURE Arthur E. K...			

18712

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Place of Birth		Date of Death		Time of Death		Cause of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Witness		Signature of Burial		Signature of Interment		Signature of Burial		Signature of Interment	
James		5 yrs		M		White		White		Roman Catholic		Single		Farmer		Baltimore, Md.		Dec. 11, 1979		10:30 AM		Heart Disease		Home		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith			
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Former																																									
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13820 CERTIFICATE OF DEATH

13801

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>		c. LENGTH OF STAY IN 1b <u>56 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET WHITEFORD SILVER</u>				4. DATE OF DEATH Month Day Year <u>Dec. 25, 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1902</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Whiteford, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Silver</u>				14. MOTHER'S MAIDEN NAME <u>Anna Whiteford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-0781</u>		17. INFORMANT <u>David Silver, Whiteford, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive C-V Disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>Dec 25</u> , 1958, that I last saw the deceased alive on <u>Dec 24</u> , 1958, and that death occurred at <u>5:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Delta, Pa</u> DATE SIGNED <u>12/26/58</u> ACTUAL SIGNATURE <u>Sorah A Hunt</u> M.D. PHYSICIAN'S NAME (Type) <u>Sorah A. Hunt M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-27-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Slateville</u>		22d. LOCATION (City, town, or county) (State) <u>Delta, York Co., Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Haskins</u>				ADDRESS <u>Delta, Penna.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13800

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford Maryland</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Harford Md.</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Harford Md.</i>			
c. LENGTH OF STAY IN 1b <i>25 yrs.</i>				d. STREET ADDRESS <i>413 N. Stokes</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Claude</i> Middle <i>K.</i> Last <i>Smith</i>				4. DATE OF DEATH Month <i>12</i> Day <i>31</i> Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/28/1888</i>	9. AGE (In years lost birthday) <i>70</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attendant -</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Long Point Vets. Hosp.</i>		11. BIRTHPLACE (State or foreign country) <i>New York</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME <i>Charles Smith</i>			
14. MOTHER'S MAIDEN NAME <i>Emma Jones</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>			
16. SOCIAL SECURITY NO. <i>Unknown</i>				17. INFORMANT <i>Paul L. Smith</i> Address <i>413 N. Stokes Harford Harford Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO <i>420.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis -</i> DUE TO <i>2 hours -</i> (c) <i>Hypertensive Cardiovascular disease -</i> DUE TO <i>10 years -</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Glomerular Nephritis -</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>			
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>12/30</i> , 1958, to <i>12/31</i> , 1958, that I last saw the deceased alive on <i>12/31</i> , 1958, and that death occurred at <i>6 A.</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Dr. Frank Wolbert</i> M.D.				ADDRESS (Street, city or town, state) <i>200 NORTH UNION AVE</i> DATE SIGNED <i>1/2/59</i>			
PHYSICIAN'S NAME (Type) <i>DR FRANK WOLBERT</i>				HARFORD DE GRACE MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>1/3/1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Harford Harford Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Franklin M. Harford Harford Md.</i> ADDRESS				24a. REC'D BY REGISTRAR DATE <i>JAN 7 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1860

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

FILE NO.

DATE OF DEATH

TIME OF DEATH

PLACE

Cause of Death

Age

Sex

Color

Occupation

Usual Residence

Place of Birth

Marital Status

Education

Religion

Previous Illnesses

Present Illness

Medical History

Family History

Autopsy

Disposition of Body

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial

Signature of Cremation

Signature of Other

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13821 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pennsylvania b. COUNTY Lebanon	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lebanon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital, Aberdeen Proving Ground, Md.		d. STREET ADDRESS 429 North 11th Street	
3. NAME OF DECEASED (Type or print) Robert Alvin Sponhower		4. DATE OF DEATH Month December Day 1 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 April 1905
9. AGE (In years last birthday) 53 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier - Sergeant	
10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? United States		13. FATHER'S NAME Unknown (Deceased)	
14. MOTHER'S MAIDEN NAME Unknown (Deceased)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	
16. SOCIAL SECURITY NO. 550-50-4025		17. INFORMANT Official Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion & edema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Failure DUE TO (c) Coronary arteriosclerosis & occlusion		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 1 , 19 58 , to Dec 1 , 19 58 , that I last saw the deceased alive on Never , 19 58 , and that death occurred at 11:50PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Stanley L. Grosshandler		ADDRESS (Street, city or town, state) US Army Hospital, APG, Md.	
PHYSICIAN'S NAME (Type) STANLEY L. GROSSHANDLER, Captain, Medical Corps		DATE SIGNED 2 Dec 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 12-4-58	22c. NAME OF CEMETERY OR CREMATORY Lebanon Pa.	
22d. LOCATION (City, town, or county) Lebanon, Pa.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Blight, Inc.		ADDRESS 6009 Harford Rd.	
24a. REC'D BY REGISTRAR DEC 8 '58		24b. REGISTRAR'S SIGNATURE William S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13801 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13804

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Philadelphia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hanover Trace</u>	c. LENGTH OF STAY IN 1b <u>75</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>75 x - 3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Barned Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Edna</u> First <u>Sternberger</u> Middle <u>Jesse</u> Last	4. DATE OF DEATH <u>December 14</u> Month <u>14</u> Day <u>19</u> Year <u>58</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 11</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>Chester Pa</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>PARLETTIE</u>	
14. MOTHER'S MAIDEN NAME <u>MC DANIEL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>JESSE STERNBERGER Jr.</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> <u>816X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident, auto, auto type</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-14-58</u> Hour <u>12:30</u> a.m. <u></u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 40</u>	20f. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <u>Bela A. W.</u> DATE SIGNED <u>12-14-58</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>12/15/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>104 HILL CEMETERY</u>	22d. LOCATION (City, town, or county) <u>Philadelphia</u> (State) <u>Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel R. Hanover</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR <u>DEC 18 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. H.</u>

13801

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13801

1
FOR STATE
HEALTH DEPT

[Faint, mostly illegible text and markings on a medical certificate form, including fields for name, date, and cause of death.]

13802 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 HAURE DE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET CRAIG TOLLINGER</u>				4. DATE OF DEATH Month Day Year <u>APR 12 1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 11, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. D. CRAIG</u>				14. MOTHER'S MAIDEN NAME <u>Katie CARROLL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>217-24-0514</u>		17. INFORMANT Address <u>MRS. RUTH V. MYERS HAURE DE GRACE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension (arterio sclerotic)</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>December 12</u> , 19 <u>58</u> , to <u>7¹⁰ AM</u> , that I last saw the deceased alive on <u>December 12</u> , 19 <u>58</u> , and that death occurred at <u>7¹⁰ AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward J. Simon</u> M.D.				ADDRESS (Street, city or town, state) <u>200 S. UNION AVE</u> DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>				ADDRESS <u>HAURE DE GRACE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC. 15, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ROCK RUN</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>HAURE DE GRACE, MD</u>				24a. REC'D BY REGISTRAR <u>DEC 15 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

B 1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13822 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE FLORIDA b. COUNTY ST LUCIE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ABINGDON (RURAL)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT PIERCE 48 X-3	
c. LENGTH OF STAY IN 1b 10 DAYS		d. STREET ADDRESS 117 SO 10th STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SRB Box 322 ABINGDON Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOSEPH SEBASTIAN TREU, SR		4. DATE OF DEATH DEC 31 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 27, 1881 77 yrs.
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WHOLESALE DISTRIBUTOR	
11. BIRTHPLACE (State or foreign country) NEW YORK CITY, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME LAURENCE TREU		14. MOTHER'S MAIDEN NAME ELIZABETH STEUERNAGEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 119-28-9548	
17. INFORMANT JOSEPH TREU, JR, ABINGDON, MD		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) UNK.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 HRS	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip W. Heuman M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED DEC 31, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 1/1/59	
22c. NAME OF CEMETERY OR CREMATORY Walter B. Cook		22d. LOCATION (City, town, or county) (State) 2135 West Chester Ave, Bronx, N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Conner		24a. REC'D BY REGISTRAR JAN 5 '59	
ADDRESS Abingdon, Maryland.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

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Walter B. Cook
Birmingham, Maryland.

2135 West Chester Ave, Bronx, N.Y.

13823 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale 03X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Choptank Avenue			
3. NAME OF DECEASED (Type or print) First FRANK Middle VYSKOCIL Last				4. DATE OF DEATH Month Dec. Day 16 Year 19 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/17/1903	
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Own Tavern		11. BIRTHPLACE (State or foreign country) Patterson, N. J.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Joseph Vyskocil				14. MOTHER'S MAIDEN NAME Frances Prochaska			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mary VanMeter Vyskocil, wife, above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis H.D. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 Hour ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from June 14, 1955 to Dec 16, 1958 , that I last saw the deceased alive on Nov 11, 1958 , and that death occurred at 3:35 p M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore - 1, Md DATE SIGNED 12/15/58							
ACTUAL SIGNATURE Sylvan D. Goldberg M.D.				DATE SIGNED 12/15/58			
PHYSICIAN'S NAME (Type) Sylvan D. Goldberg, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/20/58		22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Schimunek Funeral Home 3331 Brehms Lane				24a. REC'D BY REGISTRAR DATE DEC 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13007

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

13008 CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES W. WYBROOK		2. SEX Male		3. AGE 65	
4. PLACE OF BIRTH Baltimore, Md.		5. OCCUPATION Retired		6. MARITAL STATUS Married	
7. DATE OF DEATH Dec. 20, 1958		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN J. W. WYBROOK	
13. SIGNATURE OF REGISTRAR J. W. WYBROOK		14. SIGNATURE OF WITNESSES J. W. WYBROOK		15. SIGNATURE OF FUNERAL HOME J. W. WYBROOK	

13008 CERTIFICATE OF DEATH

1

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13808

13824

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE MARYLAND		STATE Maryland		COUNTY Harford	
CITY OR TOWN Edgewood, Rural		LENGTH OF STAY (in this place) 30 yrs		CITY OR TOWN Edgewood, Rural		(If outside corporate limits, write RURAL and give nearest town)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS /		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) ARICE		(Middle) V.		(Last) WATERS		(Month) 12 (Day) 19 (Year) 1958	
5. SEX female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Oct. 9, 1884	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Waters				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Harry Watters, Edgewood, Maryland.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				8 hours			
1143X IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE							
ANTECEDENT CAUSE(S) DUE TO (B) GENERALIZED ARTERIOSCLEROSIS				MANY YEARS			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) (WITH HYPERTENSIVE HEART DISEASE)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DIABETES MELLITUS				4 YEARS			
19a. DATE OF OPERATION NONE		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. —		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from AUGUST , 19 47 , to DEC 19 , 19 58 , that I last saw the deceased alive on SEPT 19 58 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
SIGNATURE Howard K. Waters				DATE SIGNED 12/19/58			
M.D. Box 95, Edgewood, MD.				ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/22/58		NAME OF CEMETERY OR CREMATORY John Wesley		LOCATION (City, town, or county) (State) Joppa, Harford, Maryland	
24. REC'D BY REGISTRAR DEC 23 '58		REGISTRAR'S SIGNATURE Arthur S. Thomas		25. FUNERAL DIRECTOR'S SIGNATURE Howard K. Waters		ADDRESS Box 95, Edgewood, MD.	

brother

1911, 1912, 1913, 1914, 1915, 1916, 1917, 1918, 1919, 1920, 1921, 1922, 1923, 1924, 1925, 1926, 1927, 1928, 1929, 1930, 1931, 1932, 1933, 1934, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1944, 1945, 1946, 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 25

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John Waters

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Harry Waters, Edgewood, Maryland.

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15/55/28

John Wesley

Joseph, Harold, Maryland

13803 CERTIFICATE OF DEATH

13809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>				c. LENGTH OF STAY IN 1b <i>11 days</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i> 07X-2				d. STREET ADDRESS <i>105 1/2 1st Main Street</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>H.</i> Middle <i>Alvin</i> Last <i>West</i>				4. DATE OF DEATH Month <i>December</i> Day <i>18</i> Year <i>1958</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 12, 1894</i>	
9. AGE (In years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>draftsman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Arsenal</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME <i>G. Fred West</i>		14. MOTHER'S MAIDEN NAME <i>Ella Florence Vanort</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <i>Jose M. I. West wife (same)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Liver</i> 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <i>Nov</i> , 19 <i>58</i> , to <i>Dec 18</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Dec 17</i> , 19 <i>58</i> , and that death occurred at <i>7:50 P.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dudley Phillips</i> M.D.				ADDRESS (Street, city or town, state) <i>Shelington Md</i> DATE SIGNED <i>12/18/58</i>			
PHYSICIAN'S NAME (Type) <i>Dudley Phillips</i>							
22a. BURIAL, CREMATION, REMOVAL (specify) <i>Burial</i>		22b. DATE THEREOF <i>12-21-1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Port Deposit, Md. Rural</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lee A. Patterson & Sons</i> ADDRESS <i>Perryville, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>DEC 22 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frame</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

18-03 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Print or write full name)		2. SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
3. AGE (In years, months, and days)		4. RACE (Print or write)	
5. DATE OF DEATH (Month, day, and year)		6. TIME OF DEATH (Hour and minute)	
7. PLACE OF DEATH (Print or write)		8. CAUSE OF DEATH (Print or write)	
9. MANNER OF DEATH (Print or write)		10. SIGNATURE OF DECEASED (Print or write)	
11. SIGNATURE OF WITNESS (Print or write)		12. SIGNATURE OF PHYSICIAN (Print or write)	
13. SIGNATURE OF CLERK (Print or write)		14. SIGNATURE OF REGISTRAR (Print or write)	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR ANY OTHER PURPOSES.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13810

13825 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Bel Air				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescing Home				d. STREET ADDRESS 15 Emerson Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FIELDIAN Middle ANDREW Last WHITELEY				4. DATE OF DEATH Month December Day 26 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 May 1872	
9. AGE (In years last birthday) yrs. 86		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Church		11. BIRTHPLACE (State or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bunch Whiteley		14. MOTHER'S MAIDEN NAME Mary Luttrell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ** **		17. INFORMANT Address 15 Emerson St. Aberdeen, Md. Mrs. F.A. Whiteley			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia, terminating 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic cardio-renal-vascular disease DUE TO (c) ??							INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. prostatism							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 20 , 19 58 to Dec. 26 , 19 58 , that I last saw the deceased alive on Dec. 24 , 19 58 , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Wileand P. Hudson M.D.				ADDRESS (Street, city or town, state) Forest Hill, Md.		DATE SIGNED 12/27/58	
PHYSICIAN'S NAME (Type) W.P. Hudson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/58		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John B. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE DEC 30 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. House			

Tarring Funeral Home

12-22-22 4-1 Air Memorial Gardens, Baltimore, Md.

W.D. Hudson

Robert Hill, Jr.

Dec. 22

12-22-22

Mr. Montague

Antonio Carlo - Vene - Jan. 22

Funeral in connection with

No

W.A. Hillier, Jr.

Harry Caldwell

John Wiley

Widow (Deceased) Olin

Olin

Male

10-10-22

Widow

January 22

Widow (Deceased) Olin

10-10-22

8 days

Admission

(Rural) Bel Air

12-22-22

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

13804 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>				c. LENGTH OF STAY IN 1b <u>47 yrs. 24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HARFORD Memorial Hosp.</u>				e. STREET ADDRESS <u>1617 Fountain St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Whyte</u>				4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/11/01</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shovel Op.</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Whyte</u>				14. MOTHER'S MAIDEN NAME <u>Kathryn Elizabeth Darling</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-01-7368</u>		17. INFORMANT <u>Edna C. Whyte (Wife)</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>096.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial fibrosis - possible myocarditis</u> (c) <u>Possible virus infection</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-27</u> , 19 <u>58</u> , to <u>12-28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-28</u> , 19 <u>58</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Harre de Grace</u>						DATE SIGNED <u>12-28-58</u>	
ACTUAL SIGNATURE <u>Beulah D. Hinch</u> M.D.							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>DEC 31, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WESLEYAN CHAPEL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HARFORD MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harre de Grace, Md.</u>				24a. REC'D BY REGISTRAR <u>DEC 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

There is also a link between the development of ODR technologies and increasing

81
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13805 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Har de Grace</i>		c. LENGTH OF STAY IN 1b <i>years 24</i> <i>Har de Grace</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>South Street St</i>		d. STREET ADDRESS <i>South Street St</i>	
3. NAME OF DECEASED (Type or print) <i>Stanley C Wilson</i>		4. DATE OF DEATH <i>December 21 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 24 1908</i>
9. AGE (In years last birthday) <i>50</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Diamond Dealer</i>	
11c. BIRTH PLACE (State or foreign country) <i>Har de Grace</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William A. Wilson</i>		14. MOTHER'S MAIDEN NAME <i>Albina Wright</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Francis R. Wilson, Har de Grace, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage from lacerations</i> <i>977X</i> DUE TO <i>both forearm</i> Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cut wrists with knife</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>Dec 21 1958</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Har de Grace</i> (County) <i>Harford</i> (State) <i>md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air, md.</i> DATE SIGNED <i>12-21-58</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>12/24/58</i>	22b. DATE THEREOF <i>Angel Hill</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Har de Grace, Md.</i>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Funerary Co., Har de Grace, Md.</i>		24a. REC'D BY REGISTRAR <i>DEC 29 '58</i>	24b. REGISTRAR'S SIGNATURE <i>William S. Frank</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13813

13826 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Belair	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Bonnie Ave. Rt. 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Alice Middle H. Last Woodward		4. DATE OF DEATH Month December Day 19 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1876
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Hobbs		14. MOTHER'S MAIDEN NAME Ann Marsh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. William H. Woodward		Address Bonnie Ave Rt. 3.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY FAILURE 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) PARKINSONISM DUE TO (c) ARTERIO SCLEROSIS - SENILITY INTERVAL BETWEEN ONSET AND DEATH 24 HRS 3 YRS 2 YRS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT , 19 55 , to 19 DEC , 19 58 , that I last saw the deceased alive on 19 DEC , 19 58 , and that death occurred at 12:10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE H. P. Sidwell M.D. ADDRESS (Street, city or town, state) 401 Franklin St. Balt. Md. DATE SIGNED 21 Dec 58 PHYSICIAN'S NAME (Type) H. P. SIDWELL M.D. 401 FRANKLIN ST BAL AIR. MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-1958	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DEC 24 '58	
24b. REGISTRAR'S SIGNATURE Orin S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13827 CERTIFICATE OF DEATH

13814

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle N. Last Woolford		4. DATE OF DEATH Month Dec. Day 27 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July, 20, 1977
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 1 Days 10 Hours 27 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manufacturer		10b. KIND OF BUSINESS OR INDUSTRY Marine Supplies	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.,	
13. FATHER'S NAME Napoleon B. Woolford		14. MOTHER'S MAIDEN NAME Frances J. Merritt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Francis C. Power, Leesburg, Virginia.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) arterial sclerotic heart disease DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1958 to Dec 27, 1958 , that I last saw the deceased alive on Dec 27, 1958 , and that death occurred at 8 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred O. Hodous		DATE SIGNED 12-27-58	
PHYSICIAN'S NAME (Type) Fred O. Hodous		ADDRESS (Street, city or town, state) Edgewood Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 30, 1958	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas Jr		24a. REC'D BY REGISTRAR AN 2 '59	
ADDRESS Abingdon, Maryland.		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

<p>NAME OF DECEASED Edgewood</p>		<p>RESIDENCE Edgewood</p>	
<p>DATE OF DEATH Dec. 27, 1950</p>		<p>PLACE OF DEATH Edgewood</p>	
<p>SEX male</p>		<p>RACE white</p>	
<p>DATE OF BIRTH July 20, 1917</p>		<p>AGE 33</p>	
<p>OCCUPATION Manufacturer</p>		<p>EMPLOYER Marine Supplies Baltimore, Maryland</p>	
<p>NAME OF NEXT OF KIN Napoleon B. Woolford</p>		<p>ADDRESS OF NEXT OF KIN U.S.A.</p>	
<p>CAUSE OF DEATH none</p>		<p>PLACE OF BIRTH Francis C. Power, Leesburg, Virginia</p>	
<p>DATE OF DEATH Dec. 27, 1950</p>		<p>PLACE OF DEATH Edgewood</p>	
<p>NAME OF DECEASED Fred O. Hobbs</p>		<p>RESIDENCE Edgewood, Maryland</p>	
<p>DATE OF DEATH Dec. 30, 1950</p>		<p>PLACE OF DEATH London Park, Baltimore, Maryland</p>	
<p>NAME OF DECEASED Arlington, Maryland</p>		<p>RESIDENCE Arlington, Maryland</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 21, Film G-237 1/14/59, cac.

13815

13806

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 631 Law Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS 631 Law Street	
3. NAME OF DECEASED (Type or print) John F. Wrye				4. DATE OF DEATH Month December Day 19 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 Aug. 1910		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refrigeration Eng.				10b. KIND OF BUSINESS OR INDUSTRY Refrigeration Dept. APG. Md.		11. BIRTHPLACE (State or foreign country) Penna	
13. FATHER'S NAME Franklin Wrye				14. MOTHER'S MAIDEN NAME Sarah Jane Bistline			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 193-10-7263		17. INFORMANT Mrs. John F. Wrye,		Address 631 Law St. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Enlarged Heart - Myocarditis - Mitral Regurgitation - Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) Regurgitation - Hypertension DUE TO (c) Hypertension							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 11-3 , 19 46 , to 12-12 , 19 58 , that I last saw the deceased alive on 12-12-1958 , and that death occurred at 3:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE A. L. Lewis				ADDRESS (Street, city or town, state) 214 N. Union Ave			
PHYSICIAN'S NAME (Type) A. L. LEWIS, M.D.				DATE SIGNED 12/20/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12/22/58		22c. NAME OF CEMETERY OR CREMATORY Philipsburg Cemetery		22d. LOCATION (City, town, or county) (State) Philipsburg, Penna	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE DEC 23 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Traub			

Tarring Funeral Home

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12300

Date of Birth _____		Date of Death _____	
Sex _____		Race _____	
Usual Residence _____		Place of Death _____	
Name of Deceased _____		Name of Informant _____	
Occupation _____		Cause of Death _____	
Date of Report _____		Signature of Informant _____	
Signature of Registrar _____		Signature of Physician _____	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13828 CERTIFICATE OF DEATH

13816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa, Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa, Md</u>			
c. LENGTH OF STAY IN 1b <u>8 yrs.</u>				d. STREET ADDRESS <u>Box 267</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 267</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>F.</u> Last <u>ZIOMEK</u>				4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/23/15</u>		9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philip Buenger</u>				14. MOTHER'S MAIDEN NAME <u>Frances VALENTA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-01-2063</u>		17. INFORMANT Address <u>JOSEPH A. Ziomek Box 267 Joppa MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas & Metastases</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>to liver, lung, and kidney.</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Migrating Phlebitis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/29</u> , 19 <u>58</u> , to <u>12/16</u> , 19 <u>58</u> that I last saw the deceased alive on <u>12/15</u> , 19 <u>58</u> , and that death occurred at <u>11:45</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Louis Kahan</u> M.D.				ADDRESS (Street, city or town, state) <u>Box 966 Edgewood, Md</u> DATE SIGNED <u>12/17/58</u>			
PHYSICIAN'S NAME (Type) <u>E. Louis Kahan M.D.</u>				ADDRESS <u>Box 966 Edgewood, Md</u> DATE SIGNED <u>12/17/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles D. Sadowski</u> ADDRESS <u>1937 Gough St.</u>				24a. REC'D BY REGISTRAR <u>DATE 2 2 '58</u>		24b. REGISTRAR'S SIGNATURE	

